Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING PHARMACY

Respondent Name
UNITED STATES FIRE INSURANCE CO

MFDR Tracking Number
M4-16-0666-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
NOVEMBER 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has tried for several months to have our bills processed/paid/denied with little to no success."

Amount in Dispute: $5,813.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "carrier maintains that proper jurisdiction for this claim should the State of New Mexico. This claim is currently being handled under New Mexico Workers' Compensation file number 10575522, therefore, DWC Medical Dispute Resolution does not have jurisdiction over this matter. Furthermore, dates of service prior to 11/12/14 are not eligible for medical dispute resolution as Requester failed to timely request medical dispute resolution for those dates of service."

Response Submitted by: Hoffman Kelley, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2014 through July 29, 2015	CPT Code 38779-0395-09 (14 dates) Prescription Drug – Cyclobenzaprine HCL 100%	$412.25 X 14 = $5,813.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §406.075, effective September 1, 1993, prohibits claims from other workers compensation jurisdictions from seeking benefit in the Texas Workers Compensation.

Issues

Does Medical Fee Dispute Resolution have jurisdiction to review this dispute?

Findings

On November 12, 2015, the requestor, Memorial Compounding Pharmacy, sought medical fee dispute resolution under 28 Texas Administrative Code §133.307. The requestor is seeking reimbursement of $5,813.50 for prescription drug services and report rendered on August 14, 2014 through July 29, 2015.

The respondent's representative, Dan C. Kelley, Hoffman Kelley, L.L.P., submitted a response to this request for medical fee dispute resolution on November 20. 2015. The respondent states, "This claim is currently being handled under New Mexico Workers' Compensation file number 10575522".

Texas Labor Code §406.075(a) states "An injured employee who elects to pursue the employee 's remedy under the workers ' compensation laws of another jurisdiction and who recovers benefits under those laws may not recover under this subtitle." Because the claimant pursued remedy under New Mexico's Workers' Compensation, the requestor is prohibited from seeking recovery under the Texas Workers Compensation per Texas Labor Code §406.075(a). As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division cannot recommend reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/04/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.